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STRATEGIES & SCHEMES IN FAMILY HEALTH, WELFARE & FAMILY PLANNING IN AFRICA*

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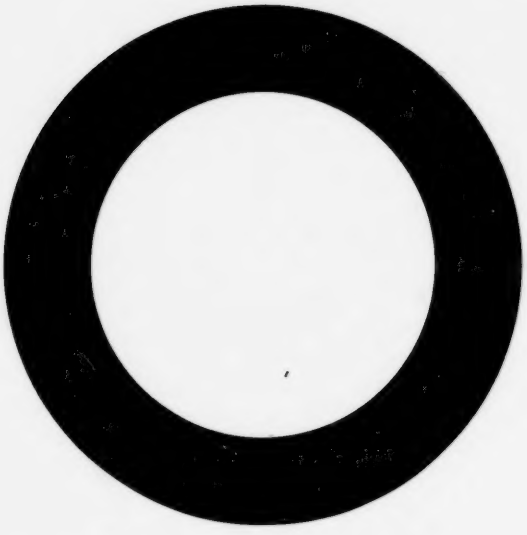
* Drafted by Ms. Sarah Loza (Population and Family Planning Board, Cairo, Egypt) For technical reasons, this paper was reproduced without formal editing. The views expressed in this paper are those of the author and do not reflect those of the United Nations.



I. Introduction

1. The purpose of this paper is to outline African strategies with regard to family health and family planning. The second section of the paper describes the demographic situation and the third policies adopted in response to the demographic situation. The fourth section takes three countries as some kind of case studies to consider the successes and failures of these countries' programmes. The fifth section considers the relative effectiveness of the measures taken in the three countries and gives recommendations.

II. Demographic Conditions in Africa

2. Africa is a region that still has to struggle to develop and implement strategies conducive to more effective and efficient interventions and adaptations to its current demographic processes to enusre the betterment of the welfare of its populations. Africa has the highest population growth rate in the world. Mortality rates though declining gradually are still relatively high. Fertility rates are either stable at high levels or increasing. To be on par with achievements of other developing countries, and to compensate for the retardation in progress that took place, Africa needs approaches that would produce frog leap results, in a relatively short period of time. With current limited resources both at national and international levels, concerted efforts are required to utilize scanty resources available to improve conditions.

3. In 1980, the population of Africa was estimated to be 470 million which constituted 11% of the total world population. With the present average rate of population growth at 3%, the population will double by the year 2000 to be 850 million (Tabah 1982:4).

4. Africa's birth rates averaged 46 per thousand between 1970-1975, compared to birth rates between 34-41 per thousand for other developing countries. East Africa has the highest total fertility rates ranging between 6.5 - 8.1, followed by North Africa (5.8 - 7.4) and West Africa (5.3 - 7.0) (Tabah 1982:5). Few countries are currently experiencing declines in fertility, but the rest of Africa have stable high fertility rates and some are even experiencing increases in fertility. Low fertility countries tend to suffer from sub-fecundity and infecundity that are expected to change with development efforts. High fertility is partially an outcome of intrinsic desire for large families supported by early and universal marriages, low levels of female education, women engaged in activities that do not conflict with child rearing, and children providing economic and old age security for parents.

5. Africa also suffers from high mortality and morbidity conditions. Life expectancy at birth increased from 37.3 years during 1950 - 1955 to 48.6 years in 1975 - 1980. This, however, is still much lower than the average life expectancy at birth for developing countries (55.1 years).

Infant mortality and child mortality rates are relatively very high, as well as maternal mortality rates (Tabah 1982:6; Gaisie 1980:17). Modern health services are concentrated in urban areas and the majority of the populations, i.e., the rural and the poor, have limited accessibility to scientific medicine and still rely heavily on traditional medicine (Gaisie 1982:20; Waife & Burkhart 1981). Poor sanitational and hygienic conditions are enforced by lack of accessibility to safe waters by almost a quarter of the population, and to waste disposal facilities for around three quarters of the population (Gaisie 1980:22). Infections and parasitic diseases aggravated by malnutrition constitute the major cause of death.

III. Policies in response to these Conditions

6. The United Nations 1981 monitoring report on population policies identified nineteen countries (37%) that consider their population growth rate as too high (1982:6-7). However, Governments' perceptions are not necessarily correlated with actual rates of population growth. Of all the countries that have estimated annual growth rates of 2.5% and above, two perceive their growth rates as low, ten perceive them as satisfactory, and thirteen countries perceive their population growth rates as too high (U.N. 1982:6-7). African governments that consider policies of intervention either to increase, maintain, or decrease rates of growth, are gradually increasing in number. Mortality, fertility, spatial distribution, and migration are the major demographic processes that may be considered to control population dynamics. So, more governments view their responsibility to intervene in one or more of these processes. Also more governments view socio-economic policies not only as necessary to cope with population trends, but rather as essential to indirectly alter these trends.

7. Fertility reduction is considered by certain African countries as necessary means of reducing population growth rates to ameliorate national development strains. Other African countries view fertility reduction as a measure to improve the wellbeing of individuals and families. There are a range of actions utilized by governments to modify reproductive behaviour of couples and to improve their levels of living. Some governments resort to legal measures to legalize access to contraception, abortion, and sterilization or to increase age at marriage. Others introduce technical and administrative measures to integrate family planning services within health services or within basic community structures. Incentives and disincentives have also been used by governments to increase birth control motivations. Publicity and educational campaigns have been used to increase knowledge, awareness and hence provide psychological changes in attitudes. Some countries consciously resort to development strategies to introduce changes in certain socio-economic factors, i.e., improvement in educational level and status of women, redistribution of income and increase of earnings, etc.. All these options have produced a variety of strategies with differential levels of committment by governments to affect fertility rates of populations.

8. Reduction of mortality rates, on the other hand, are considered by almost all governments as desired goals to improve living conditions and wellbeing of their populations. To achieve their goals, a range of actions have been adopted by specific governments. These include extension of health services coverage specifically in deprived rural areas; control of endemic diseases through improvement in environmental sanitation, immunization, and improvement in maternal and child health conditions; provision of potable water; improvement in nutritional status; investments in training of health workers and health education; increase in community involvement in health aspects, etc.. Due to scanty resources both in funds and trained personnel, there has been a shift in strategies to improve mortality and morbidity conditions by emphasizing certain aspects of primary health care strategies. However, the novelty of this approach in addition to many financial, administrative, political and/or structural constraints impede the potential of this approach and limit its implementation. (Tabah 1982:15; United Nations 1982:29; Waife & Burkhart 1981).

9. The proliferation of political systems in Africa is parralleled by a proliferation of strategies, schemes, or lack thereof, as measures to cope with population dynamics and family health and welfare objectives. This report will review in greater details strategies and schemes introduced in three countries: Kenya, Tunisia, and Egypt. These countries have been selected on the basis that their governments have recognized the negative impact of the population rate of growth and the mortality and morbidity conditions. They have well professed population policies and have opted for direct and indirect intervention schemes to ameliorate these conditions for almost two decades. Hence the analysis of the impact of these schemes may provide a platform for the discussion of effective strategies and programs to improve family, maternal, and child welfare.

IV. Strategies of Selected Countries

A. KENYA

10. Kenya is a country with a population of 16.5 million and an annual growth rate of 3.9%. Rising fertility and slow decline in mortality are responsible for this high rate of population growth. Crude birth rate has been estimated by UNFPA (1983:211) to be 53.8 per thousand and Crude death rate to be 14.4 per thousand. The urban population constitutes only 14.4% of the total population, and in 1972, three quarters of households were receiving annual incomes below the minimum level of welfare requirements (UNFPA 1978:13).

11. The Government of Kenya recognized the negative implications of population conditions and has introduced through the Ministry of Health, a family planning program since 1969. The government policy is to reduce population growth rate by reducing fertility through making family planning information, education, and services available on request for the welfare of the mother and children. Hence the family planning program is closely linked with Mother and Child health services, and family planning services are freely provided in hospitals and health centres.

12. The strategy of the population policy was to improve the family welfare and increase life expectancy through reduction of infant, child, and maternal mortality and through lowering fertility by spacing of children and by prevention of undesirable births rather than through a reduction in family size as an objective per se.

13. No conscious efforts are directed toward introducing institutional changes that will discourage large family norms. The government general development policy aims at decreasing the development gap between urban and rural areas. This is to be achieved by increasing employment opportunities in rural areas and by increasing and improving the standard of services there, including health and educational services, building of roads, and provision of potable water sources (UNFPA 1978:15).

14. Though the Government of Kenya relies heavily on sectorial plans for development and concentrates on development of rural areas, somehow population objectives are not well integrated into these plans (UNFPA 1978:19).

15. Family planning activities are integrated within health services, mainly mother and child health services. There are several assumptions behind this strategy. First there is a hypothesized link between reduction of infant and child mortality and reduction in fertility. Second, there is the assumption that a significant demand for family planning exists and so provision of family planning services within MCH Centers will lower fertility. Thirdly, family planning is an integral part of primary health care concept in addition to mother and child health services, environmental sanitation, nutrition, and control of communicable and vector borne diseases.

16. With the shortage of medical personnel, the government relied on expansion of service delivery points, mobile teams, and rural health demonstration centers manned by health educators and trained community nurses. The government also invested in Nurse Training Schools.

17. This strategy has been successful in achieving reductions in infant and child mortality but did not achieve reductions in fertility (UNFPA 1978: 66-67). Impressive rates of new acceptors are reported (FPAK 1979), yet drop out rates are high and contraceptives are used to substitute for traditional methods of birth control such as lactation and abstention.

18. A study that compared data from KAP study in 1966/1967 with results of Kenya Fertility Survey in 1977/1978 reached the conclusion that fertility aspirations have not changed. However, the program achieved greater knowledge of contraceptives in Metropolitan areas and improved the quality of knowledge of contraceptives in rural areas (Thomas & Werner 1981).

19. The analysis of the Kenya Fertility Survey data also indicates that 87.4% of the sample desired more than six children as a family size and never used an efficient method of contraception. Those who desired less than six children and ever used efficient contraception were only 4.4% of the sample (Thomas & Werner 1982). So there is a need for greater efforts to deal with negative perceptions of family planning contraceptive methods as well as a need to promote small family size values. Accessibility (subjective and objective) has a positive relation to contraceptive use at the onset of a program, yet programs working on providing supplies and services and/or on changing of attitudes will have less impact than when other indirect variables are manipulated simultaneously too (Kar & Talbot 1980: 55-57).

20. Kenya still lacks the "social setting" and is low in "program efforts" which may support a successful family planning program (Freedman & Berelson 1976). In addition to a greater need to improve accessibility of health, family planning services in rural areas and among the urban poor, greater efforts have to be exerted to integrate population dimensions within developmental efforts.

B. TUNISIA

21. Tunisia in contrast to Kenya enjoys a higher level of development. Around 52% of 6.4 million population reside in urban areas with a relatively high average per capita gross national product of $1,120. Tunisia also has a relatively high literacy rate, school enrollment, and an average life expectancy of 57.4 years for males and 58.4 years for females (UNFPA 1981: UNFPA 1983).

22. The population average growth rate of 2.5% between 1975-1980 which is the lowest in North Africa is viewed as high by the Tunisian Government because of high unemployment rates. The government has a comprehensive population strategy to improve family welfare and reduce the population growth rate.

23. The government embarked on several activities and schemes to achieve this dual objective. The National Family Planning Program started in 1966 supported by population education in schools and out of schools. Health services were expanded and improved. Legislation was utilised to facilitate contraceptive practice, legalize abortion and sterilization, and raise the minimum age at marriage for males and females. Legislation was also used to improve the status of Tunisian women by abolishing polygamy and Islamic Law, securing sex equality in work situations, increasing minimum age of work, providing free education, extending free medical care and retirement benefits to agricultural workers, and manipulating tax exemptions, child allowances, and social welfare payments to encourage small families (UNFPA 1981:58-59).

24. The government also embarked on rural development programs to decrease regional disparities and to regroup highly dispersed populations into new village communities to increase accessibility to services. Data collection operations are considered essential and efforts are exerted to improve them as population data are integrated in national and regional development plans.

25. This comprehensive population strategy was successful in reducing national fertility rates. The model age of contraceptive use changed from 30-34 years to 25-29 years. The average number of living children by acceptors decreased (UNFPA 1981: 54). Infant mortality rates dropped to a general estimate of 100 per thousand live births as well as child mortality rates.

26. Nevertheless, the success story seems to be levelling off. Acceptance rates have declined since 1977 (UNFPA 1981: 55). Several factors seem to be contributing to this development. First, the reservoir of potential family planning acceptors may be drying up. Secondly, there is an increased knowledge and perception of negative side effects of contraceptive methods that may be discouraging new acceptors. Thirdly, certain percentage of women are not reached by the services. The existing Ministry of Health rural infrastructure used for family planning services is not sufficient for coverages of total rural population. Mother and child health units cover only 25% of the overall needs (UNFPA 1981: 2). Fourthly, there seems to be a drop in family planning impetus and a decline in quality of service. Monetary incentives paid for physicians, mid-wives, and nurses were removed and this may have decreased the personal involvement of the personnel in the program.

27. An evaluation, carried out by a team sponsored by U.S. A.I.D. concluded that "problems (faced by the family planning program) are more managerial and administrative in nature than of a basic technical or policy nature" (UNFPA 1981:58). UNFPA Needs Assessment Mission arrived at a similar conclusion. Deficiencies are due mainly to failure in coordination and concerted planning of the several overlapping responsibilities of several agencies both at the national and regional levels.

C. EGYPT

28. By mid 1983, Egypt's population was estimated to be 46 million with an average rate of growth close to 3% annually. The crude death rate has declined consistently reaching nearly 10 per thousand by 1980. The crude birth rate declined significantly from 1966 to 1972. The trend reversed and a gradual increase in birth rates occured annually till 1981. Currently, estimates indicate a decline in birth rates.

29. The government became alarmed at the rate of population growth and officially established a national family planning program in 1965 aiming at fertility reduction through provision of family planning services, information and education. Since 1973, the government became more aware of the limitation of the traditional family planning approach and the multidimensional nature of the national population problem, i.e., high growth rate, maldistribution of the population, and unfavourable population characteristics especially in terms of health, education and status of women. The population problem was then integrated within a developmental approach relating population dynamics to socio-economic environment. Nine socio-economic factors were identified as critical to population dynamics, mainly fertility. These are: socio-economic standard of the family, education, status of women, mechanization of agriculture, industrialization, infant mortality, social security, information and communication, and family planning delivery services. The government strategy was to manipulate these factors simultaneously to bring about changes in the reproductive behaviour of couples.

30. Family planning services are jointly the responsibility of the Ministry of Health and the Ministry of Social Affairs through the activities of voluntary organizations. The implementation of national and sectorial programs became the responsibility of local governments at regional and village levels. A Population and Development Program was established in twelve governorates (regions) to support and consolidate the local family planning and population responsibilities specified by the local government law and to promote community participation and involvement in planning, implementing and supervising activities that have population objectives for the community. An overall activity of this program is the upgrading of the managerial skills of local governmet councils, the appointed and the elected, as well as local informal leaders to be able to set population targets, design and implement projects, and mobilize community participation. These projects include community based socio-economic development programs, cultural activities to promote information and communication through community institutions such as mosques, youth clubs, and through community outreach workers.

31. The Population and Development Program (PDP) has a built in periodic evaluation schemes. All evaluation findings indicate that PDP has a slight positive impact on the use of contraceptives and on the attitudes of women toward contraception when PDP villages are compared to non-PDP villages. The difference, however, is not great, but still encouraging. One basic achievement of the Program is the fact that community leaders of 70% of all Egyptian villages are now aware of national and local population problems that they discuss monthly in committees. Hence the process of decentralizing and integrating population issues within the developmental local plans is actually in action.

32. Egypt, unlike other African countries, enjoys an extensive health infrastructure that is well distributed all over the country. Studies indicate that most of these health facilities are under-utilized. The standard of services need to be upgraded. including family planning services. Like the Tunisian case, family health and welfare projects suffer from managerial inadequacies rather than conceptual dificiencies in strategies.

V. Requirements for effectiveness of Programs:

33. The three cases reviewed represent a range of strategies, goals, and schemes directed toward improving family welfare, health, and family planning with different degrees of effectiveness. The Tunisian case seems to be the most successful. The government has not only provided family planning services, information, and education aggressively, but also with a great degree of committment intervened in other non-demographic aspect of development that lead both to success of population strategies as well as improvements in family welfare and health. This has been supported and enhanced by the general level of development of the country as well as its strong and stable political system.

34. Egypt's limited effectiveness of its strategies lies partially in the fact that the government overall committment to the problem is inadequate. In addition, the majority of families still value large families as a viable survival strategy to better cope with existing social and economic conditions. The high illiteracy rates of mothers, the need for financial support from children, and the sanitary and environmental conditions among the urban poor and rural population all contribute to relatively high fertility and infant and child mortality rates. So the limited demand for contraceptives limits, in its own right, the impetus to the program that might have taken place in case of success.

35. Kenya, on the other hand, still adopts a traditional family planning approach directed toward the wellbeing of the family. In countries where large families are valued as a reflection of existing socio-economic conditions, effectiveness of family health programs will be limited unless they are well integrated within general overall policies of development.

36. Part of the development strategy is to improve the informational and awareness level of households in issues related to health, family planning and family welfare. Outreach activities have the potential of increasing the level of health education of families such as the Health Education Worker in Kenya and the Health Home Visitor or Raida Rifia (Rural female pioneer) in Egypt. These programs have to be an important integral part of any scheme rather than just an out product. Also a well coordinated plan for information, education, and communication activities is important utilizing mass media channels as well as the formal and informal educational channels for in-school and out of school health and population education.

37. Coordination of sectoral activities horizontally and vertically is also an important managerial aspect for success of strategies and schemes. Often coordination is even lacking among foreign donor agencies. Coordination may be enhanced by encouraging continuous evaluation and research efforts with proper dissemination of results among decision-makers as well as other researchers.

38. For the effectiveness of any program equal attention has to be paid to the supply side as well as the demand side. Efficiency of the service is as important as the effective demand for the service. Interventions to deliver services or to upgrade services must be parralleled by interventions to increase the demand for the service. That is especially so when the service requires innovative actions or changes in the established behavioural patterns of the people.

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